SWGA SOUTHWEST GASTROENTEROLOGY ASSOCIATES, P.C.

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Authorization to Obtain Medication History

Patient Name: _____
DOB: _____
Address: _____
Pharmacy:_____

By signing below, I hereby authorize Southwest Gastroenterology to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Date of Authorization_____

_____
Patient/Legal Representative or Parent/Legal Guardian Print Name

_____
Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Southwest Gastroenterology Associates may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.